Barrington Public Schools – Student Health History Form

Name of Child:_____ DOB:_____ Gender:_____ Grade:_____
Address:_____ Phone:_____
Physician Name:_____ Physician Number:_____ Dentist Name: _____
Name of prior school:_____ City/Town, State: _____

Please check any health concerns that apply and provide additional information on lines:

ALLERGIES:
☐ Food: _____ ☐ Medication: _____
☐ Insect: _____ ☐ Environmental: _____
My child requires allergy precautions:
☐ Epipen for school ☐ Nut free table/classroom
My child has experienced these allergy symptoms:
☐ Rash ☐ Swelling ☐ Hives ☐ Trouble Breathing
☐ Vomiting ☐ Diarrhea ☐ Local Reaction

My child follows a special diet: _____

ASTHMA/ RESPIRATORY CONDITIONS:
☐ Triggers: _____
☐ Needs inhaler at school: ☐ Yes ☐ No
☐ Frequent colds ☐ Nosebleeds ☐ Bronchitis
☐ Frequent strep throat ☐ Pneumonia
☐ Other: _____

BLOOD DISORDERS:
☐ Sickle cell disease ☐ Anemia ☐ Hemophilia
☐ Other blood disorder/condition: _____
☐ Precautions/Restrictions: _____

EMOTIONAL/ BEHAVIORAL CONCERNS:
☐ ADHD
☐ Other: _____
☐ Treatment/Medication: _____

CONGENITAL DISORDERS:
☐ Cystic Fibrosis ☐ Spina Bifida
☐ Other: _____

DENTAL CONCERNS:
☐ Multiple cavities/fillings ☐ Braces/orthodontic device
☐ History of tooth injury: _____

DIABETES:
☐ Type I ☐ Type II
☐ Needs medication at school: _____
☐ Needs blood sugar monitoring at school: _____

DIGESTIVE/ ELIMINATION:
☐ Frequent stomachache ☐ Constipation ☐ Diarrhea
☐ Bladder/Bowel control problems ☐ Other: _____

HEART CONDITION:
☐ Type: _____
☐ Physical Restrictions: _____
☐ Other Precautions: _____

HEARING DIFFICULTIES:
☐ Hearing loss, type: _____
☐ Frequent ear infections ☐ History of ear tubes (removed)
☐ Ear tubes present in: ☐ Right ear ☐ Left ear
☐ Assistive hearing device: _____
☐ Classroom accommodations:
☐ Special seating: _____ ☐ Other: _____

HOSPITALIZATION and/or INJURY:
☐ Date: _____
☐ Reason/ Treatment: _____

MUSCULAR/ SKELETAL and/or MOBILITY NEEDS:
☐ Muscular Dystrophy
☐ Other Muscular/Skeletal conditions: _____
☐ Wears/uses orthopedic device: _____
☐ Needs wheelchair
☐ Classroom accommodations: _____

NEUROLOGICAL CONDITIONS:
☐ Frequent headaches ☐ Migraines ☐ Cerebral Palsy
☐ Other neurological condition: _____

SEIZURE CONDITIONS:
☐ Tonic clonic ☐ Absence ☐ Focal
☐ Frequency of seizures: _____
☐ Date of last seizure: _____
☐ Medication at school: _____

SURGERIES:
☐ Date: _____ Type: _____

VISION PROBLEMS:
☐ Difficulty seeing: ☐ Distance ☐ Near
☐ Lazy eye ☐ Strabismus (cross eye)
☐ Wears glasses ☐ Wears contacts
☐ Date of last eye exam: _____

MEDICATIONS:
☐ Taken at home: _____ ☐ Taken at school: _____

All medications given at school require a signed physician's order and parent/guardian permission. Please speak with the school nurse.

Does your child have: ☐ 504 Plan ☐ IEP ☐ Other medical concerns not listed above: _____

This information will become part of your child's school health record and may be shared with appropriate school personnel for educational and safety purposes.

Parent/Guardian Signature:_____ **Date:** _____